IN THE DISTRICT COURT OF THE UNITED STATES
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

Willie Strickland, #226537	)	
	)	
Plaintiff,	)	
	)	
vs.	)	CIVIL ACTION NO. 2:05-CV-931-F
	)	
Samuel Rayapati, et.al.,	)	
	)	
Defendants.	)	
	)	

AFFIDAVIT

Before me, the undersigned Notary Public, did personally appear J. C. Giles, who being duly sworn, deposes and presents the following affidavit.

My name is J. C. Giles and I am an individual over the age of twenty-one years. I am employed with the State of Alabama Department of Corrections at Ventress Correctional Facility, Clayton, Alabama. I am employed in this capacity as a Warden III. I have read the complaint in the above styled case and note that inmate Willie Strickland, #226537 alleges that I violated his civil rights. I make this affidavit in the defense thereof.

The plaintiff, Willie Strickland, #226537, listed me as a defendant in his complaint that was delivered to me on October 17, 2005. In the narrative of his complaint, the plaintiff alleges that he has been neglected of physical well being. He alleges that he has been to the Health Care Unit numerous times to have his hernia fixed and was turned down.

In my capacity as Warden III at Ventress Correctional Facility, I have insured that Inmate Willie Strickland, #226537 has access to medical care and that he is being taken care of at the Health Care Unit at Ventress Correctional Facility. I have talked with the Health Care Unit and he is being monitored.

The before mentioned facts are true and correct to the best of my knowledge.

11-28-05
J. C. Giles Date

State of Alabama)

Barbour County)

Sworn to and subscribed before me this 28th day of Nov., 2005.

Notary Public
My Commission Expires: 9-08-08

State of Alabama
Alabama Department of Corrections
Ventress Correctional Facility
P.O. Box 767
Clayton, Alabama 36016

Bob Riley
GOVERNOR

Donal Campbell
COMMISSIONER

A F F I D A V I T

)
)
)
)

STATE OF ALABAMA

I, Reba T. Currie, hereby certify and affirm that I am an ASAIII, at Ventress Correctional Facility; that I am one of the custodian of records at this institution; that the attached documents are true, exact, and correct photocopies of certain documents maintained here in the institutional files; and that I am over the age of twenty-one years and am competent to testify to the aforesaid documents and matters stated therein.

I further certify and affirm that said documents on Willie Strickland, 226537 are maintained in the usual and ordinary course of business at the Ventress Correctional Facility; and that said documents were made at, or reasonably near the time that the transactions referred to therein are said to have occurred.

This, I do hereby certify and affirm to on this the 16th day of Dec, 2005.

Reba T Currie
Signature

SWORN TO AND SUBSCRIBED BEFORE ME THIS 16th DAY OF December, 2005.

Carolyn Daniels
Notary Public
My Commission Expires: 04/06/06

Telephone (334) 353-3883 Fax (334) 353-3967

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME:

D.O.B. / /
ALLERGIES:

Use Last Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /
ALLERGIES:

Use Fourth Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Strickland, Willie
226537

D.O.B. 12/28/73
ALLERGIES: NKA

Use Third Date 10/31/05

DIAGNOSIS (If Chg'd)
AIC. BBB

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Strickland Willie
226537

D.O.B. 12/28/73
ALLERGIES: NKA

Noted Dr. Martin 8-25-05 1035

Use Second Date 8/25/05

DIAGNOSIS (If Chg'd)
L R ADD K
Motrin 200mg Tid PO BID x 1m
Heavy lifting 7.5# x 6m

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: STRICKLAND, WILLIE
#226537

D.O.B. 12/28/73
ALLERGIES: NKA

Noted RC 7.21

Use First Date 7/21/05

DIAGNOSIS
BB Prof 4 x 6 months
Cont wearing hernia belt
x 6 mon Prof
RTC PRN

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Strickland Willie #226537 7/18/05 D.O.B. 12/28/73 ALLERGIES: NKDA 513 Use Last Date 7/18/05	DIAGNOSIS (If Chg'd) BBPx4days. V.O. Dr. Rayapati / ... ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Strickland, Willie #226537 1807 D.O.B. 12/28/73 ALLERGIES: NKDA 2/21/05 Use Fourth Date / /	DIAGNOSIS (If Chg'd) Truss — 6 mo Rsz 6 mo for F/U ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Strickland, Willie #226537 noted B. ... RN 6-17-04 1230 D.O.B. 12/28/73 ALLERGIES: NKDA Use Third Date 6/14/04	DIAGNOSIS (If Chg'd) Surgery Consult for R I H. ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Strickland, Willie #226537 Noted ... 6/3/04 D.O.B. 12/28/73 ALLERGIES: NKDA Use Second Date 6/3/04	DIAGNOSIS (If Chg'd) Lay in profile ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Strickland, Willie #226537 Noted ... 5-17-04 D.O.B. 12/28/73 ALLERGIES: NKDA Date 5/17/04	DIAGNOSIS Truss — RIH ☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

PHS
PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Strickland, Willie 226537 D.O.B.: 12/28/73
2-22-05/1037	Wt. 193# BP 110/70 P 76 R 18 T 99.2 - c/o hernia, pre-existing problem — [signature]
	(O) RIH - very small
	reducible - easily
	IM - Exaggerating
	NT
	A RIH - IM is using same
	reducible device - ? scrotal
	support
	P) may use Truss
	(S) do not strain - [illegible]
7-21-05/1115	190# - 99.8 - 110/58 - 80 - 18 - req. bottom bunk profile — [signature]
	31 y WM for C/o [illegible] of Hx of (R) inguinal hernia
	x 2 yrs denies ? in size [illegible]
	Meds US) [illegible] [illegible] NKDA
	ABD Soft NT (R) Lower ABD
	Swelling BS + x4 hernia
	very small non detectable wearing hernia
	A (R) inguinal hernia truss today
	P cont hernia truss & [illegible]
	E BB Profile & [illegible]
	Report any ? size or N/V/D or pain [illegible]
	RTC PRN [signature]

60111 (5/89) [Com]plete Both Sides Before Using Another S[hee]t

Date/Time	Inmate's Name: Strickland Willie D.O.B.: / /
8-25-05 810	wt 190, T 98.8, R18, P68, O2 sat 98%, B/p 124/70
	C/O hernia lower groin (Right side) painful
	S/ wm [illegible] x 18 months smells
	NAD USS A&Ox3 Ambulates [illegible]
	ABD soft flat Hernia retractable [illegible] truss
	on as directed. denies [illegible] in BM
	⊕BS x4 ⊖swelling ⊖masses noted
A	RL ABD hernia easily reducable ⊘ [illegible]
P/Tx	Cont to wear truss
	⊘ Heavy lifting 215 # x 6 months
	↑ Fluids Safety c̄ work/Play
	RTC PRN Motrin 200mg ii po BID x 1 month PRN
	Hall [illegible]
10/21/05	wt. 181# P 75 T 98.4 B/p 100/66 R 18
	C/o hernia abdomin
	did not show up

Date/Time | **Inmate's Name:** Strickland, Willie 226537 **D.O.B.:** 12 1[illegible] 173

6/3/04 Wt. 190 B/P 128/66 P74 R16 T98

S) Hernia

O) Has small RIH - Reducible - NT - has BBB/Truss - Abd soft NT, No palpable masses, NL BS - Other exam - NL.

(A) RIH - small

P) Lay in profile -

[signature]

6-14-04/1055 Wt 193 B/P 100/74 P70 R18 T99.2 - C/o hernia
C Hunter, LPN

S/O Hernia (RIH - small - reducible

S) diagnosed 5/17/04

O) on standing a small RIH - palpable that disappears on supine position - NT - benign - diagnosed a month ago - Hernia site - seems normal size - No significant dilation of (R) inguinal ring
The rest of the exam [illegible] [illegible] normal. -
The letters from IM, to HSA, and Warden noted

(A) Small RIH

on profile - Truss not at provided - 2° shortage of supply, will soon will provide -

P) IM wants surgery - Will write a surgery consult for approval

[signature]

PHS
PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Strickland, Willie #226537 D.O.B.: 12/28/73
5-7-04/1030	Wt 189.5 B/p 100/60 P 61 R16 T 98.6 - c/o @ abd. pain
	x 1 week C. Hunter, LPN
	Wants BBB.
	O) Abd NT Soft BS-NL
	(A) Normal Exam
	P) denied BBB
	[signature]
5/17/04	Pain Rt groin area
1035	Wt 191lbs P-76 R-18 T98.8 Pulse ox 98% BP 122/60
S)	O)
	Some swelling comes at 6pm. in R groin area.
	Now some reproducible tender near any
	pubic pain, without any Erythema and
	swelling. no swelling now.
	other Exam - NL Cough Reflex ⊗
	Hernia site NL
	(A) - ? prodromal R I H
	?' mild musculoskeletal pain
	Malingering for BBB
	P) Come and show when swelling seen
	[signature]

60111 (5/85) C[omp]lete Both Sides Before Using Another Sh[eet]

PRISON HEALTH SERVICES, INC.

SICK CALL REQUEST

Print Name: Willie P Strickland Date of Request: 8-23-05
ID # 226537 Date of Birth: 12/28/73 Location: 10-B 37B
Nature of problem or request: Pre-existing hernia. Injured myself obeying a direct order from DOC. I'm in a great deal of pain. This is my last attempt to get the surgery before I pursue legal action. I've been hurting about 20 mos. To with 1983.

Willie Strickland 226537
Signature

DO NOT WRITE BELOW THIS LINE

Date: 8/24/05
Time: 2:15 AM (PM)
Allergies: NKDA

RECEIVED
Date: 8/24/05
Time: 11:45
Receiving Nurse Intials DS

PF 8/25/05

02Sat=98%

(S)ubjective: I'm still hurting. They gave me a hernia brace, I just want to get the surgery done with. I still have 3½ yrs. to do.

(O)bjective (V/S): T: 98° P: 59 R: BP: 112/74 WT: 187
w/amb, NC UC steady gait - A/O x 4 C/O pain 8-9 from hernia. States when he 1st got brace it helped but it doesn't help any more.

(A)ssessment: Pt in comfort. (Note: Pre-Existing - $3.00 fee)

(P)lan: Appt. with Ms. Floyd, CNP 8/25/05 8/26/05

Refer to: ~~MD~~/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CNP
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

Willie Strickland

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Willie Strickland Date of Request: 5-14-04
ID # 226537 Date of Birth: 12-28-77 Location: 3-Dorm
Nature of problem or request: Pain in right of Stomach beside Groin area

Willie Strickland
Signature

DO NOT WRITE BELOW THIS LINE

Date: 5/14/04
Time: 1945 AM PM
Allergies: NKA

RECEIVED
Date: 5-14-04
Time: 12:30
Receiving Nurse Intials DS

(S)ubjective: "I need some [illegible] done about my right side and groin area."

(O)bjective (V/S): T: 98.8 P: 78 R: [illegible] BP: 120/80 WT: 190

C/O right side abd pain [illegible] groin area @ times, NO swelling or [illegible]

(A)ssessment: Complt and advd

(P)lan: See Dr Rayapati 5-17-04 @ 10am

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic
CIRCLE ONE

Check One: ROUTINE (X) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

[signature]
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Willie Strickland Date of Request: 5-5-04
ID # 226577 Date of Birth: 12-28-72 Location: 3-Dorm 79-T
Nature of problem or request: Severe abdominal pain on right side

Willie Strickland 226577
Signature

DO NOT WRITE BELOW THIS LINE

Date: 5/6/04
Time: 8:00 AM (PM)
Allergies: NKA

RECEIVED
Date: 5-6-04
Time: 12:30
Receiving Nurse Intials DS

(S)ubjective: Started hurting about a week ago but it keep getting worse.

(O)bjective (V/S): T: 99.4 P: 80 R: 20 BP: 110/70 WT: 190

no extreme pain when pressure applied, no bld, tenderness, redness [illegible]

(A)ssessment: Alt. Comfort

(P)lan: Refer to Dr. [illegible] Friday 8:00 am. 5-7-04

Refer to: (MD)/PA Mental Health... Dental... Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

RECEIVED FEB 28 2005

Form must be Complete and Legible. You must Type or Print
Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: VENTRESS-0641
Site Phone #: 334-7758178
Site Fax #: 334-775-8178
Will there be a charge? ☐ Yes ☐ No
Sex: ☑ Male ☐ Female

Patient Name: (Last, First): Strickland Willie
Alias: (Last, First):
Inmate #: 226537
SS Number: ___-___-___

Date: (mm/dd/yy) 2,25,05
Date of Birth: (mm/dd/yy) 12 28 73
PHS Custody Date: (mm/dd/yy) __/__/__
Potential Release Date: (mm/dd/yy) __/__/__

Responsible party: ☐ PHS ☐ Ado Inc. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental
Dr. Rayapati

Facility Medical Director Signature and Date: Samuel Rayapati, MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)
☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__
(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy
Number of Visits/Treatments: ____ ☐ Other: ______

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery: Dr Whyte

History of illness/injury/symptoms with Date of Onset: Small Rt H- with No significant sac. easily Reducible

Results of a complaint directed physical examination: P/E- Examination Reveals no significant change from the past

Previous treatment and response (including medications): New Prosent [illegible] TRUSS-

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.
☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:
☐ Alternative Treatment Plan (explain here):
☐ More Information Requested: (See Attached)
☐ Resubmitted with requested information.
☐ OffSite Service Recommended and Authorized

I/ reducable -> Truss

Date/Initials: __/__/__

Regional Medical Director Signature, printed name and date required:
Will Mosier, MD 3/1/5 (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: | Med Class: | UR Auth #:

UM Referral review form 2-05-2004

Fax 2-28-05

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

PHS

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: VENTRESS-0845	Patient Name: (Last, First) Strickland Willie	Date: (mm/dd/yy) 2/25/05
Site Phone # 334-7758171	Alias: (Last, First)	Date of Birth: (mm/dd/yy) 12/28/73
Site Fax # 334-775-8178	Inmate # 226537	PHS Custody Date: (mm/dd/yy) __/__/__
Will there be a charge? ☐ Yes ☐ No	SS Number ___-__-____	Potential Release Date: (mm/dd/yy) __/__/__
Sex ☑ Male ☐ Female		

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid): _____

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr. Rayapati

Facility Medical Director Signature and Date:

Samuel Rayapati MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (RX) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DM)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other: _____

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery:

Dr. White

History of illness/injury/symptoms with Date of Onset:

Small RUA - with no Significant Sac. easily Reducible

Results of a complaint directed physical examination:

F/U - Examination. Reveals no Significant Changes from the past

Previous treatment and response (including medications):

Now Prescribed - TRUSS

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required:

__/__/__

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

Fax 2-28-05

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Please print in Complete and Legible. You must Type or Print
Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number:	Patient Name: (Last, First)	Date: (mm/dd/yy)
VENTRESS-0444	Strek Landville	06/14/04
Site Phone #	**Alias: (Last, First)**	**Date of Birth: (mm/dd/yy)**
334-7758178		12/28/23
Site Fax #	**Inmate #**	**BHS Custody Date: (mm/dd/yy)**
334-775-8178	226537	01/21/03
Will there be a charge? ☐ Yes ☐ No **Sex** ☐ Male ☐ Female	**SS Number** 423-23-0212	**Potential Release Date: (mm/dd/yy)** 12/8/07

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific: (Excludes Medicare and Medicaid)

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dentist

Dr Samuel Kayapeh

Facility Medical Director Signature and Date:

Samuel Kayapeh M.D.

☐ Service meets criteria for "approval via protocol"

Place a check mark (√) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other: ____

Specialist referred to: Surgery

Type of Consultation, Treatment, Procedure or Surgery:

Eval for Surgery of a Small RIH - Benign and reducible.

History of Illness/Injury/symptoms with Date of Onset:

A month ago a small RIH - easily reducible, only visible on long standing and easily reduced on Supine Abdominal exam

Results of a complaint directed physical examination:

Small RIH - easily reducible Non-Tender - With no Signs of Cord dilatation of Right inguinal ring - No other Complications

Previous treatment and response (including medications):

Will Trial a Truss will be Supportive - But it Feels he will be more Comfortable with Surgery

He has BBB - and Lazy in Profile

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here): → In reducable, conservative RX

☑ More Information Requested: (See Attached) Date requested: ___/___/___ Fleetwood

☐ Re-submitted with requested information.

Regional Medical Director Signature, printed name and date required: MOSLEY 01.16.04

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type | Med Cert # | UR Auth #

UM Referral review form 2-05-2004

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: VENTRESS-0845	Patient Name: (Last, First.) Strickland Willie	Date: (mm/dd/yy) 6,14,04
Site Phone #: 334-7758178	Alias: (Last, First.)	Date of Birth: (mm/dd/yy) 12,28,23
Site Fax #: 334-775-8178	Inmate #: 226537	PHS Custody Date: (mm/dd/yy) 6,12,03
Will there be a charge? ☐ Yes ☐ No / Sex ☐ Male ☐ Female	SS Number: 423-23-6213	Potential Release Date: (mm/dd/yy) 2,28,09

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid): ____

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Samuel Rayapati

Facility Medical Director Signature and Date: Samuel Rayapati M.D.

☐ Service meets criteria for "approval via protocol"

History of Illness/injury/sypmtoms with Date of Onset: a month ago a small RIH – easily reducible, only visible on long standing and easily reduced on supine position diagnosed

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Results of a complaint directed physical examination: Small RIH – easily reducible Non-Tender – with no significant dilatation of Right inguinal ring – no other complications

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy ☐ Other: ____

Number of Visits/Treatments: ____

Specialist referred to: Surgery

Type of Consultation, Treatment, Procedure or Surgery: Eval for Surgery of a small RIH – Benign and reducible.

Previous treatment and response (including medications): Will Form a Truss will be supplied – But in status he will be more comfortable with Surgery
IM has ABB – and lay in profile

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: ___/___/___

Returned Denied 6-16-04

Regional Medical Director Signature, printed name and date required: ___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

faxed 6-16-04

UM Referral review form 2-05-2004